



STATE OF  
**KANSAS**

# Health Plan Summary

**Open Enrollment**

**2005**

October 1, 2004 through November 1, 2004

<http://www.accesskansas.org/employee>

*It's About Your  
Health!*

## QUICK REFERENCE GUIDE

### MEDICAL PROVIDERS

Kansas Choice . . . . .	Outside Topeka . . . . .	800-332-0307
	In Topeka . . . . .	785-291-4185
Coventry Health Care . . . . .	Kansas City Area . . . . .	800-969-3343
	Wichita Area . . . . .	866-320-0697
Kansas Prefer . . . . .	All locations. . . . .	800-882-3639
Preferred Health Systems. . . . .	Outside Wichita . . . . .	866-618-1691
	In Wichita . . . . .	316-609-2555
Preferred Plus of Kansas . . . . .	Outside Wichita . . . . .	866-618-1691
	In Wichita . . . . .	316-609-2555
Premier Blue. . . . .	Outside Topeka . . . . .	800-332-0028
	In Topeka . . . . .	785-291-4010

### LAB CARD SERVICES

LabOne . . . . .	All Areas . . . . .	800-646-7788
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### DENTAL PROVIDER

Delta Dental Plan of Kansas . . . . .	Outside Wichita . . . . .	800-234-3375
	Wichita. . . . .	316-264-4511

### PRESCRIPTION DRUG PROVIDER

CaremarkPCS. . . . .	All Areas . . . . .	800-294-6324
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### VISION PROVIDER

Superior Vision Services . . . . .	All Areas . . . . .	800-507-3800
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### FLEXIBLE SPENDING ACCOUNTS

ASI . . . . .	All Areas . . . . .	800-366-4827
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Service provider web site links can be found at: <http://da.state.ks.us/ps/subject/benlink.htm>

### NOTE:

The information in this booklet is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document or contract which contains the complete provisions of a program. In case of any discrepancy between this booklet and the legal plan document or contract, the legal plan document or contract will govern in all cases. You may review the legal plan document or contract upon request or view them at our website: <http://da.state.ks.us>. The Health Care Commission reserves the right to suspend, revoke or modify the benefit programs offered to employees. Nothing in this booklet shall be construed as a contract of employment between the State of Kansas and any employee, nor as a guarantee of any employee to be continued in the employment of the State, nor as a limitation on the right of the State to discharge any of its employees with or without cause.

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## Message from the Governor



I am pleased to join the State of Kansas Health Care Commission in announcing the 2005 Health Insurance Plan. We continue to strive to provide health plan participants with comprehensive, cost-effective choices. There are only a few changes in the benefit package for 2005, notably some HMO county additions and suspension of the Health Risk Appraisal.

We are all concerned with the increasing cost of health care. Reports indicate a 13.5% increase nationally for 2004, marking the fourth consecutive year of double-digit premium increases. I commend the members of the Health Care Commission for their effort to make the most of our limited resources and their work to contain premium increases below the national inflation trend.

The State is continuing its commitment to provide choices for employees and continuing its contribution approach toward health insurance. The State will again contribute approximately 95% of the cost of single only coverage and 35% for dependent coverage based on the lowest cost HMO, unless the participant lives in an area with no HMO availability, then the contribution is based on the lowest cost PPO. Other options will be available to participants, but they will continue to pay the difference in the cost of premium. This contribution approach engages participants and heightens awareness of the true cost of their health care choices.

The State continues to allow you to pay your premiums with pre-tax dollars and to set aside funds in a pre-tax account for qualified medical expenses. Some examples are expenses such as deductibles, copays and coinsurance that are not covered by the health plan. The pre-tax account, called the Health Care Flexible Spending Account, can assist you in paying for medical expenses and have a significant impact on your tax liability. I encourage you to check with your Human Resources director to learn more about the advantages of the Health Care Flexible Spending Account.

Please take the time to understand your benefits and to be active partners with the State of Kansas in controlling health care costs. This booklet and the state employee benefits web site offer many tools to assist you as you decide which health care plan best suits you and your family this next year.

Thank you for the service you give to the people of Kansas. One of my highest priorities as Governor is to find ways to make health coverage more affordable to state employees and other working Kansans, and to improve the quality of health care that Kansans receive. If you have problems or concerns, please talk with your human resources director. We want to be sure State of Kansas employees are confident and comfortable with the health care options provided.

*Kathleen Sebelius*

### Are There Benefit Plan Changes for 2005?

There are no plan design changes for Plan Year 2005. However, the Health Risk Appraisal program has been discontinued for 2005. In order to bring all benefits eligible employees to an equal status, the premium credit will be applied to all employee enrollments during Plan Year 2005. This will be accomplished by adjusting the employee portion of the dental premium to \$0.00 for full-time employees. For Plan Year 2005 and beyond, other approaches to addressing employee health issues will be investigated and considered along with companion programs that encourage healthy lifestyle adjustments that lead to disease prevention or early identification and treatment.

### Must Everyone Review Their Health Care Plans?

Yes. The Open Enrollment period from October 1 through November 1, 2004 is your opportunity to begin, verify, or make changes to your benefit elections. This is the only time changes to your current health and dental elections can be made until next year's Open Enrollment period unless you experience a qualifying event (see page 35).

Whether you are enrolling for the first time, changing to a different plan or coverage level, waiving your health, drug and dental coverage or making a flexible spending account election, you must complete the online enrollment process.

## When Does Coverage Begin?

Changes and new rates become effective January 1, 2005.

## What Happens After November 1 When Open Enrollment Is Complete?

- Confirmation Statements will be available on the Employee Self Service Center by the second week of December.
- Verify your elections with the printout of your saved elections from Open Enrollment. If an error has been made in processing your elections, contact your Human Resources office by December 17, 2004.

## When Will Payroll Deductions for the 2005 Plan Year Begin?

Your January 14, 2005 paycheck will reflect your Plan Year 2005 rates and elections. Employee contributions for the Health Plan and KanElect FSA's are deducted on a semi-monthly basis – 24 times (16 for certain regents employees) per year. There will not be a deduction for either KanElect or the Health Plan from the third paycheck in the months during Plan Year 2005 which have three paychecks (July and December).

# Summary of Plans

## Medical Plans

The Health Plan will offer two (2) types of plan designs and six (6) providers for Plan Year 2005.

- Health Maintenance Organizations (HMO):
  - Coventry Health Care
  - Preferred Plus of Kansas
  - Premier Blue
- Preferred Provider Organizations (PPO):
  - Kansas Choice - administered by Blue Cross Blue Shield
  - Kansas Prefer - administered by Harrington Benefit Services
  - Preferred Health Systems Insurance Company

## Lab Card Services

LabOne card for participants in Kansas Choice or Kansas Prefer plans

## Dental Plan

Delta Dental Plan of Kansas

## Prescription Drug

CaremarkPCS

## Vision Plan (Optional)

Superior Vision Services

## KanElect - Flexible Spending Accounts

Administered by ASI

# Steps to

## Create Your Personal Care Plan

### **STEP 1** Review your current health care needs, coverage and budget

Life changes, and so do health care needs and costs. While you might prefer to ignore the whole business and just keep the plans you had this year, it's well worth your time to confirm that this year's plan still fits, or to choose a different plan. In addition to preparing for sickness, regular medical or dental check-ups or other preventive care may help you keep your personal and family medical costs down in the long term. Even though medical, prescription drug and dental costs are rising, the State of Kansas continues to pay about 95% of the cost of the employee coverage and 35% of dependent coverage.

Many of our health plans are self insured, meaning the State Health Plan pays our claims for medical, prescription drug and dental costs. Being self-insured helps to keep premiums lower and provides more coverage per dollar spent. It also means that adopting lifestyles which lead to good health can have a direct and positive effect on the bottom line.

### **STEP 2** Read this booklet

We've all heard about factors like rising provider fees and the cost of research and new technologies that seem to be driving up our premiums. There is one major factor that is being overlooked: the treatments covered are growing in number and improving greatly. People are visiting the doctor more often, too.

Once you've thought about what you might need next year in terms of medical coverage – flexibility, network of providers, etc., and what you can afford to pay, use the Table of Contents in this booklet and refer back to these steps to guide you through the decision-making process. This booklet includes information on how to choose health care, as well as benefit and rate comparisons, and other useful aids to help you make your decisions. Take the time to study the plans offered, balancing costs and care options, before you make your benefit elections.

### **STEP 3** Attend an Open Enrollment meeting to learn more about your options

Your agency will let you know the dates and times of the meetings near you. Still need more information? Go to [www.accesskansas.org/employee](http://www.accesskansas.org/employee). There you'll be able to access the Benefits Administration website.

## **STEP 4 Complete the online enrollment process**

Beginning October 1, 2004, State of Kansas employees can enroll online through the Employee Self Service Center for Plan Year 2005 Health Plans and Flexible Spending Accounts.

An employee must enter the Employee Self Service Center on the accessKansas website to make Health Plan changes, or to participate or renew participation in a Flexible Spending Account for Plan Year 2005. Employees not wanting to make any changes to their Health Plan, and not wanting to enroll in a Flexible Spending Account, are not required to enroll online. The Employee Self Service Center is also the site all non-regents employees access to view pay advices. Regents employees can use the Employee Self Service Center to participate in Open Enrollment and to view a confirmation statement of benefit elections.

### **Employee Self Service Center**

**<http://www.accesskansas.org/employee>**

#### **What User ID and Password Do I Use to Access the Open Enrollment Website?**

To access the Employee Self Service Center, you will be required to use your Employee ID.

- Employee ID – The 11-digit ID that starts with a capital letter can be found on your paycheck or stub or by contacting your Human Resource Office.
- Password
  - Current users of the Employee Self Service Center - enter your existing password.
  - First time users of the Employee Self Service Center – you will be able to create an initial password by entering your birthdate (format must be MM/DD/YYYY including slashes) as the password. You will then be prompted to change the password to something personal that will be retained.

## To Enroll

**<http://www.accesskansas.org/employee>**

**Use** a computer with Internet access when and where it is convenient - work, home, Job Service Centers, many public libraries.

**Go** to the Employee Self Service Center website at:

**<http://www.accesskansas.org/employee>**

**Select** "Employee Self Service Center" then "Login". Follow the instructions on the screen.

**Update** your profile by including an email address and setting up a secret question and answer.

**Select** "Benefits Open Enrollment".

**Follow** the on-screen instructions. Many screens include links that provide additional information regarding the topic.

When finished, **select** "Submit/save changes".

**Print** a confirmation of saved selections.

**Logout** and close the browser.

### Forgot your password?

Answer your secret question online and receive a new password immediately on the screen. If necessary, call the Help Desk to receive a new password.

### Need help on the website?

The Help Desk is open 24 hours a day and can be reached at 785-296-1900 or toll free at 866-999-3001. The Help Desk can only assist with signing in to the Employee Self Service Center. Staff cannot answer questions about benefit options. For benefit options questions, contact your agency's Human Resource office, email **Benefits@da.state.ks.us** or go to: **<http://www.accesskansas.org/employee>**

## General Information

### Employee Advisory Committee

The EAC provides a vehicle for participants to express ideas and concerns about the Kansas State Employees Health Plan to the HCC and its staff.

The Employee Advisory Committee (EAC) was established by the Health Care Commission (HCC) in the mid-1990's. As provided in KSA 75-6510, the EAC is to advise the HCC on matters relating to health care benefits of state officers and employees and to assist the HCC in the development of policy and determination of rates of such benefits.

The EAC is composed of 21 members including active employees and retirees. Each member serves a three-year term. Members are selected on a basis of geographic location, agency, gender, age and plan participation. This is to assure that the membership represents a broad range of employee and retiree interests.

The EAC holds regular meetings at least quarterly. Subcommittees meet between quarterly meetings. Current subcommittees are: Plan Design and Benefits; Retirees; Wellness/Communication and Advocacy. EAC members also have involvement in the carrier selection process.

If you are interested in being involved and giving input into important health plan decisions and making recommendations to the HCC, please write the Health Benefits Office, Attn: EAC, 900 SW Jackson, Room 920-N, Topeka, Kansas 66612 or e-mail:

**Benefits@da.state.ks.us**, no later than October of each year.

Please feel free to contact any of the EAC members in order provide ideas and suggestions for improvement to the Health Plan. For more information about the committee, see <http://da.state.ks.us/hcc/advisory.htm>

### Employer and Employee Contribution

The State contributes toward the cost of health coverage. Currently, for full-time employees, the employer share is approximately 95% of the cost of single coverage and 35% of the cost of dependent coverage of the lowest cost plan.

To encourage competition among health plans as well as to encourage wise consumerism by plan participants, the State will continue with the contribution approach that began with Plan Year 2004. The State has been divided into two areas - one where HMOs are available, and one where only PPOs are available. In each area, the employer contribution will be

based on the lowest cost plan in the area. You can select from among the plans available in the county where you live. If the plan you select is not the lowest cost option, you will pay the difference, or buy-up to the plan of your choice.

Rate comparison charts are located on pages 22 and 23 of this booklet. The rates listed for each medical plan include the cost for medical and prescription drug coverage only. Dental and vision rates are listed separately in the dental and vision sections.

### Coverage Period

Health Plan coverage is monthly. New enrollments or changes in enrollment and/or coverage will generally begin on the first day of the month. Terminations of coverage or ineligibility for coverage will be effective on the last day of the month.

### Pre-Existing Conditions

The State of Kansas does not apply a waiting period for pre-existing conditions for newly eligible employees and their dependents. However, orthodontic treatment must start after the effective date of dental coverage.

### Identification Cards

Beginning in Plan Year 2005, all plans except vision will be using an identification number other than your social security number (SSN) on your ID cards. You will receive a new ID card for any plan in which your current card shows your SSN or for any plan in which you make an Open Enrollment change. Cards will be mailed to the employee's home address starting in mid-December.

If you have not received a new ID card for a plan in which you are expecting one by the first part of January, contact the health plan at the telephone number listed in the front of this booklet to request one.

### Plan Certificates

It is important that you review your Certificate of Coverage. The information in the Medical Plan Comparisons by Plan Type chart in this booklet is only intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the Certificate of Coverage, which is the controlling document. Determinations of entitlement to benefits are made based on the Certificate of Coverage. Please review your Certificate of Coverage if you have any questions about benefits. The Certificates of Coverage may be viewed on the web at <http://da.state.ks.us/ps/subject/benlink.htm>

# How to

## Choose Health Care Coverage

### **Review your current health care needs, coverage and budget**

- Decide who is going to be covered.
- Do you travel out of state for extended periods?
- Do you have dependents living (going to school) out of state?
- Ask your co-workers if they have used their health care program and how satisfied they are with their plan.
- Read through the Open Enrollment materials. If you do not understand something, ask your agency Human Resources officer and/or attend an Open Enrollment meeting.

### **Choice of Providers**

- Determine what medical providers (hospital and doctors) you would like to use.
- Do you want to continue with doctors or specialists with whom you are already familiar?
- Do you want the option of going outside a network of health care providers?
- Is your provider's office close to home or work?
- What procedure is required for an emergency or hospitalization?
- Are providers taking new patients?

### **Coverage**

- What is the current health condition of you and your covered dependents?
- Examine your health care needs. Are there any health conditions that need to be considered? Do you anticipate different health care needs in the coming year?
- What planned changes do you have in the coming year...retirement, move, etc.?

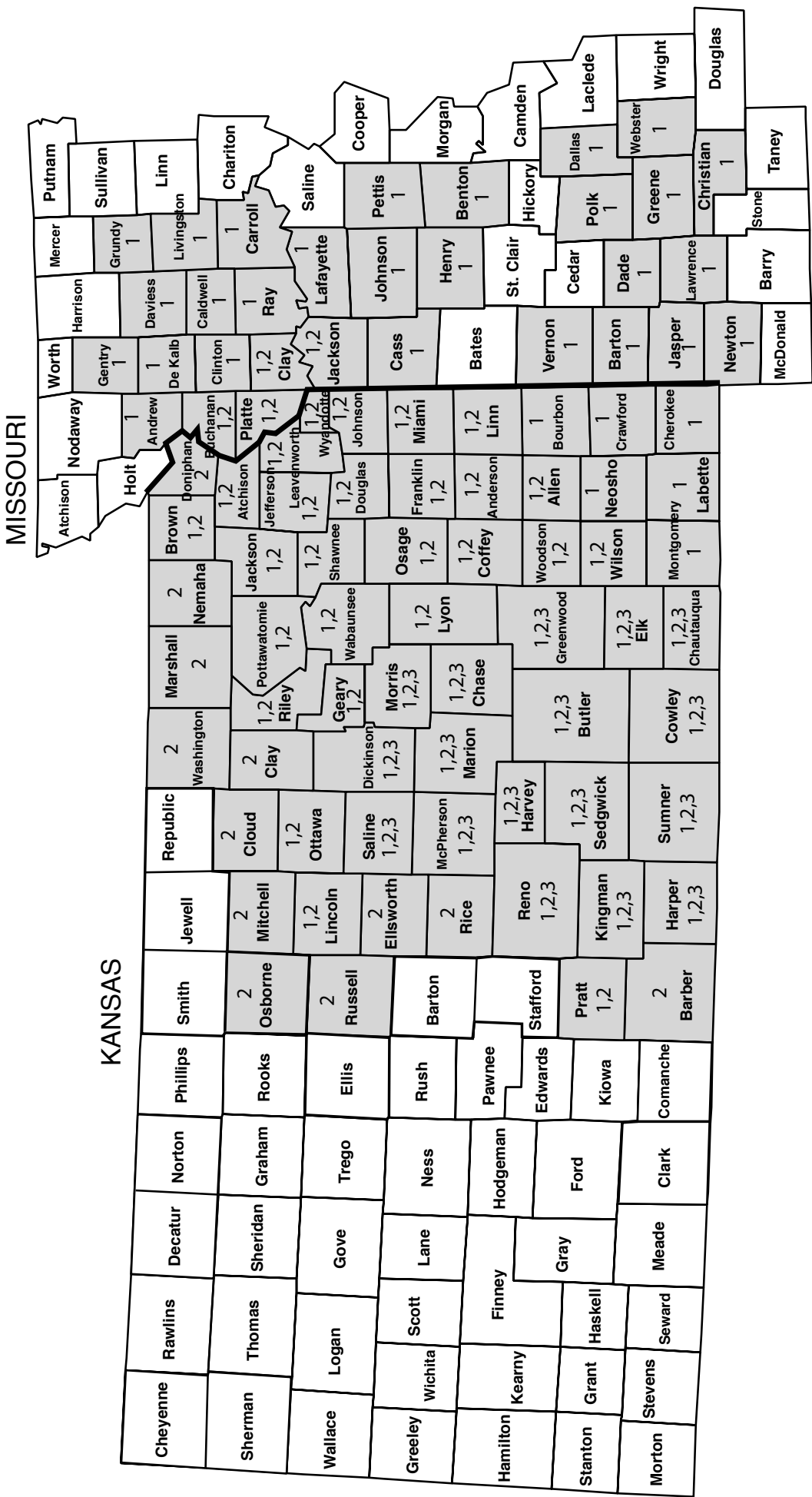
### **Cost**

- Note the cost of each plan (both premium and out-of-pocket expenses).
- How much can you afford to pay?
- Is the freedom of choice of doctors more important than the cost of the plan?

### **FACT** **Premiums**

and deductibles/copays work like a seesaw. Hold one down and the other goes up. Find your balance based on your health care needs and cash flow.

## 2005 Enrollment Eligibility Plan Options by County



## Key

- 1= Coventry Health Care  
2= Premier Blue  
3= Preferred Plus of Kansas

Eligibility for enrollment in Kansas Choice, Kansas Prefer, and Preferred Health Systems is in all counties in Kansas and Missouri and in most other states. Check with each of these health plans for locations of contracting physicians and provider networks.

Eligibility for HMO is indicated by the shaded countries on the map above.

## Choosing an HMO versus PPO

There are two types of health programs offered in the State of Kansas Health Plan - Health Maintenance Organizations (HMO) or Preferred Provider Organizations (PPO).

### HMO

An HMO program offers you a limited number of providers. You must select a Primary Care Physician (PCP) for yourself and your covered dependents. In an HMO program, all services require prior approval or referral by the PCP, except if otherwise noted. If you travel for extended periods of time or have dependents going to school or otherwise living out of the HMO service area, an HMO may not be the best choice.

**ALL services require prior approval or referral by the participant's Primary Care Physician (PCP) except where noted otherwise.**

### Keys to using HMOs

- PCP selection. Verify eligibility with the health plan before a primary care physician (PCP) selection is made. Make sure the PCP is taking new patients. All provider directories are available at: <http://da.state.ks.us/ps/subject/benlink.htm>
- Changes in PCP selection. Call the medical plan with your changes. Changes will become effective the first of the month following notification to the HMO plan.
- Seeking treatment. Call your PCP before seeking treatment. It is the PCP's responsibility to direct your treatment.
- Treatment by a specialist. All medical services must be coordinated through each covered participant's PCP or HMO plan. This includes any treatment recommended by a specialist to whom the participant has been previously referred.
- Referrals by PCP to a specialist. All referrals from your PCP to a specialist must be obtained PRIOR to the receipt of services. If there is a medical reason for using a specialist that does not contract with the health plan, your PCP must seek authorization from the HMO plan before a referral is made. Services not authorized are not covered.
- Emergency room visits. All emergency room visits for emergency medical conditions must be reported to the HMO plan within a specified period of time-usually 24 to 48 hours. In cases of life or limb threatening emergencies, you should seek help immediately. For non-life or limb threatening situations, you should call your PCP before seeking treatment.
- Emergency services out of area. Any participant temporarily outside the enrollment area will be covered for emergency services only.
- Out of area services. Services are limited to initial treatment of an accident or emergency. Routine or elective care is not covered outside the service area.
- Non-emergency hospitalizations. All non-emergency hospital admissions must be authorized in advance by the HMO plan.
- Urgent care. Care needed on evenings, weekends, or holidays must be coordinated by the PCP.
- Dental accidents/injuries. Claims for treatment of dental accident/injuries must first be submitted to the dental plan for payment of covered services. Your PCP must refer for all specialty services subsequently eligible for coverage for the medical plan.
- Well Woman Exam. Women may visit an OB/GYN physician participating with their HMO plan for an annual well woman exam without a referral from their PCP.
- Well Man Exam. Men may visit a urologist/proctologist who participates with their HMO plan for an annual well man exam without a referral from their PCP.

**NOTE:** It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

## PPO

PPO programs offer you the ability to go to any doctor or hospital (more choice). PPOs have contracted networks. Not all doctors and hospitals are in each network. If you go to a doctor or hospital out of the network, you will still be covered but will pay more for care. Review the network to see if the doctors and hospitals you prefer contract with that health plan. If they do not, that plan option may not be the one for you. Ask yourself if you are willing to change doctors or hospitals in order to have this program. Make note of the non-network deductible and coinsurance.

In the State Health Plan, there are significant differences in the networks of the three PPOs being offered. The three PPO plans have a standardized benefit structure that is outlined in the Comparison Chart.

**PPOs offer more flexibility, but at a cost.**

### Keys to using PPOs

- **Provider selection.** Provider Directories are available at:  
<http://da.state.ks.us/ps/subject/benlink.htm>  
Verify that your providers are in the health plan you are considering before plan selection is made.
- **Claims paid.** All claims are paid based on the contracting status of the provider of service at the time the service is performed.
- **Other providers involved in your treatment.** Ask your physician for the names of any other providers (i.e., anesthesiologist, assistant surgeon, laboratory, etc.) that may be involved in your treatment. This allows you to check their contracting status before any services are performed.
- **Preventive Care Service Allowance.** The PPO plans feature a Preventative Care Service Allowance of \$300 per person per year for specified wellness services. This allowance applies only for routine wellness services provided by network or contracting providers. Services provided to treat an illness or by non-network providers will be subject to deductible and coinsurance.
- **Using non-network provider.** You may use a non-network provider. The plan will pay the claim based upon their allowed charge for procedures. You will be responsible for any difference between the plan allowance and the actual charge. This difference could result in additional out-of-pocket expenses for you. Ask the provider if they will accept the plan's allowance as payment in full.
- **Dental accidents/injuries.** Claims for the treatment of dental accidents/injuries must first be submitted to the dental plan for payment of covered services. Services covered by the dental plan are not eligible for reimbursement through the medical plan.

**NOTE:** It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

## 2005 Plan Comparison Chart

**Health Maintenance  
Organization (HMO)**  
  
**Coventry Health Care,  
Preferred Plus of Kansas,  
Premier Blue**

**Preferred Provider  
Organization (PPO)**  
  
**Kansas Prefer -  
using the PHCS network,  
Kansas Choice -  
using the Blue Choice network**

**Preferred Provider  
Organization (PPO)**  
  
**Preferred Health Systems**

### BASIC PROVISIONS

		<u>Network</u> n/a	<u>Non-Network</u> \$500 single/\$1,500 family	<u>Network</u> n/a	<u>Non-Network</u> \$500 single/\$1,500 family
<b>Deductible</b> (not included in coinsurance maximums)	n/a				
<b>Coinsurance 1</b>	10%	<u>Network</u> 50%	<u>Non-Network</u> 50%	<u>Network</u> 50%	<u>Non-Network</u> 50%
<b>Coinsurance Maximum 1</b> (does not include deductible or copayments)	\$1,000 single/\$2,000 family	<u>Network</u> \$1,100 single/ \$2,200 family	<u>Non-Network</u> \$1,450 single/ \$2,900 family	<u>Network</u> \$2,200 single/ \$4,400 family	<u>Non-Network</u> \$3,650 single/ \$7,300 family
<b>Coinsurance 2</b>	n/a	<u>Network</u> 30%	<u>Non-Network</u> 30%	<u>Network</u> n/a	<u>Non-Network</u> n/a
<b>Coinsurance Maximum 2</b> (does not include deductible or copayments)	n/a	<u>Network</u> \$1,100 single/ \$2,200 family	<u>Non-Network</u> \$2,200 single/ \$4,400 family	<u>Network</u> n/a	<u>Non-Network</u> n/a
<b>Total Coinsurance Maximum</b> (does not include deductible or copayments)	\$1,000 single/\$2,000 family	<u>Network</u> \$2,200 single/ \$4,400 family	<u>Non-Network</u> \$3,650 single/ \$7,300 family	<u>Network</u> \$2,200 single/ \$4,400 family	<u>Non-Network</u> \$3,650 single/ \$7,300 family
<b>Copayment Summary -</b> see specific category for detail on copayments.					
Physician Office Visit	\$20 PCP / \$30 Specialist	<u>Network</u> n/a (Coins. applies)	<u>Non-Network</u> n/a	<u>Network</u> n/a (Coins. applies)	<u>Non-Network</u> n/a
Outpatient Mental Health (Not Biologically Based)	\$25	\$25	\$25	\$25	\$25
Inpatient Services*	\$200 per admission	\$300 per admission	\$600 per admission	\$300 per admission	\$600 per admission
Emergency Room Visit*	\$75	\$100	\$200	\$100	\$200
Urgent Care Facility Visit	\$30	n/a	n/a	n/a	n/a
Outpatient Surgery*	\$100 per surgery	n/a	n/a	n/a	n/a
Major Diagnostic Tests*	\$100 per test	n/a	n/a	n/a	n/a
<b>Lifetime Benefit Maximum</b>	\$2,000,000 per person	\$2,000,000 per person		\$2,000,000 per person	
<b>Primary Care Physician (PCP)</b> PCP manages and/or directs all care.		PCP not required.		PCP not required.	
<b>Provider Choice</b>	Local Network. Referrals required for care not by Primary Care Physician.	Freedom to use provider of choice. Benefits based on plan description. Coverage level based on provider network status.		Freedom to use provider of choice. Benefits based on plan description. Coverage level based on provider network status.	
<b>Out of Network Care</b>	Must be referred by PCP and pre-approved by Health Plan. Subject to coinsurance and applicable copayments	Subject to deductible, coinsurance and applicable copayments		Subject to deductible, coinsurance and applicable copayments	
<b>Out of Area Care</b>	Covered only for initial treatment of medical emergency or if pre-approved by Health Plan. Subject to coinsurance and applicable copayments.	Subject to deductible, coinsurance and applicable copayments		Subject to deductible, coinsurance and applicable copayments	
<b>Amounts Above Plan Allowance</b>	Provider to write off	<u>Network</u> Provider to write off	<u>Non-Network</u> Member responsibility	<u>Network</u> Provider to write off	<u>Non-Network</u> Member responsibility

\* These copayments not included in coinsurance maximums. These services may require coinsurance.

## 2005 Plan Comparison Chart

**Health Maintenance  
Organization (HMO)**  
  
**Coventry Health Care,  
Preferred Plus of Kansas,  
Premier Blue**

**Preferred Provider  
Organization (PPO)**  
  
**Kansas Prefer -  
using the PHCS network,  
Kansas Choice -  
using the Blue Choice network**

**Preferred Provider  
Organization (PPO)**  
  
**Preferred Health Systems**

### COVERED SERVICES

		<u>Network</u>	<u>Non-Network</u>	<u>Network</u>	<u>Non-Network</u>
<b>Inpatient Services</b>	\$200 copayment per admission, then subject to coinsurance. Copayment does not apply towards coinsurance maximum.	\$300 copayment per admission, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	\$600 copayment per admission, then subject to coinsurance. Deductible does not apply. Copayments do not apply towards coinsurance maximum.	\$300 copayment per admission, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	\$600 copayment per admission, then subject to coinsurance. Deductible does not apply. Copayments do not apply towards coinsurance maximum.
<b>Outpatient Surgery</b>	Subject to \$100 copayment per surgery, then subject to coinsurance. Copayment does not apply to coinsurance maximum.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.
<b>Ambulance Services</b>	Subject to coinsurance	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.
<b>Major Diagnostic Tests</b> (includes but not limited to: PET Scans, CT Scans, Nuclear Cardiology Studies, Magnetic Resonance Angiography and Computerized Topography Angiography)	Must be pre-approved by Health Plan. Subject to \$100 copayment per test then subject to coinsurance. Copayment does not apply to coinsurance maximum.	Must be pre-approved by Health Plan <u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded & coins.	Must be pre-approved by Health Plan <u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded & coins.
<b>Other Outpatient Services</b>	Subject to coinsurance	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.
<b>Physician Office Visits</b>	Subject to office visit copayment. \$20 for PCP, \$30 for all other office visits. Copayments do not apply towards coinsurance maximum.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.
<b>Physician Hospital Visits</b>	Subject to coinsurance	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.
<b>Emergency Room Visits</b>	\$75 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	<u>Network</u> \$100 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	<u>Non-Network</u> \$200 copayment (waived if admitted) then subject to deductible and coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	<u>Network</u> \$100 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	<u>Non-Network</u> \$200 copayment (waived if admitted) then subject to deductible and coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.
<b>Urgent Care Facility Visits</b>	\$30 copay plus coinsurance. Copayment does not apply towards coinsurance maximum.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.
<b>Home Health Care</b>	Services must be pre-approved by Health Plan. Limited to \$5,000 per benefit period. Subject to coinsurance.	Services must be pre-approved by Health Plan. Limited to \$5,000 per benefit period. <u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to \$5,000 per benefit period. <u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.
<b>Hospice</b>	Services must be pre-approved by Health Plan. Limited to \$7,500/lifetime. Subject to coinsurance.	Services must be pre-approved by Health Plan. Limited to \$7,500/lifetime. <u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to \$7,500/lifetime. <u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.

## 2005 Plan Comparison Chart

	<b>Health Maintenance Organization (HMO)</b> <b>Coventry Health Care, Preferred Plus of Kansas, Premier Blue</b>	<b>Preferred Provider Organization (PPO)</b> <b>Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network</b>	<b>Preferred Provider Organization (PPO)</b> <b>Preferred Health Systems</b>
<b>Surgery/Anesthesia/Asst. Surgeon</b>	Subject to applicable inpatient or outpatient copayments, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	<u>Network</u> Subject to coinsurance	<u>Non-Network</u> Subject to ded. & coins.
<b>Physical Rehabilitation Services</b> (Including Chiropractic)	Services must be pre-approved by Health Plan. Inpatient limited to 60 days. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. Office visit copay plus subject to coinsurance.	Services must be pre-approved by Health Plan. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. <u>Network</u> Subject to coinsurance	Services must be pre-approved by Health Plan. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. <u>Non-Network</u> Subject to ded. & coins.
<b>Durable Medical Equipment</b>	Services must be pre-approved by Health Plan. Subject to coinsurance. Limited to \$5,000 of covered services per person per year.	Services must be pre-approved by Health Plan. Limited to \$4,500 of covered services per person per year. <u>Network</u> Subject to coinsurance	Services must be pre-approved by Health Plan. Limited to \$4,500 of covered services per person per year. <u>Non-Network</u> Subject to ded. & coins.
<b>Allergy Testing</b>	As approved by Primary Care Physician. Subject to \$30 Specialist office visit copay, then coinsurance. Copays do not apply towards coinsurance maximum.	As approved by Health Plan. <u>Network</u> Subject to coinsurance	As approved by Health Plan. <u>Non-Network</u> Subject to ded. & coins.
<b>Antigen Administration</b> (desensitization/treatment) - Allergy Shots	As approved by Primary Care Physician. Subject to applicable office visit copay, then coinsurance. Copays do not apply towards coinsurance maximum.	As approved by Health Plan. <u>Network</u> Subject to coinsurance	As approved by Health Plan. <u>Non-Network</u> Subject to ded. & coins.
<b>Infertility Treatment</b> (limited to testing & 3 attempts at artificial insemination per year)	As approved by Primary Care Physician. Subject to \$30 Specialist office visit copay, then coinsurance. Copays do not apply towards coinsurance maximum.	As approved and precertified by Health Plan. <u>Network</u> Subject to coinsurance	As approved and precertified by Health Plan. <u>Non-Network</u> Subject to ded. & coins.
<b>Childhood Immunizations</b> to Age 6	Covered at 100% as required by state mandate.	Covered at 100% as required by state mandate.	Covered at 100% as required by state mandate.

## MENTAL HEALTH

<b>Inpatient Nervous &amp; Mental/Drug &amp; Alcohol</b>	Subject to inpatient copayment, then subject to coinsurance. Copayment does not apply towards coinsurance maximum. 60-day limit per year.	<u>Network</u> Subject to inpatient copayment, then subject to coinsurance. Copayments do not apply towards coinsurance maximum. 60-day limit per year.	<u>Non-Network</u> Subject to inpatient copayment, then subject to deductible and coinsurance. Copayments do not apply towards coinsurance maximum. 30-day limit per year.
<b>Outpatient Nervous &amp; Mental/Drug &amp; Alcohol</b>	First 3 visits @ 100%, next 22 visits - \$25 copay; additional visits @ 50%	Both in and out-of-network visits will be counted towards the first 25 visits. <u>Network</u> First 3 visits @ 100%, next 22 visits @ \$25 copay, additional visits @ 50%	Both in and out-of-network visits will be counted towards the first 25 visits. <u>Non-Network</u> First 3 visits @ 100%, next 22 visits @ 50%, 25 visit limit.
<b>Biologically Based Mental Health Conditions</b>	Benefits same as medical conditions for biologically based mental health conditions.	Benefits same as medical conditions for biologically based mental health conditions.	Benefits same as medical conditions for biologically based mental health conditions.

# 2005 Plan Comparison Chart

## Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue

## Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network

## Preferred Provider Organization (PPO) Preferred Health Systems

### ADULT PREVENTIVE CARE

Preventive Care Services (One per calendar year for each service)	Must be provided by network providers. See specific categories below.	Network Preventive Care Allowance = 1st \$300/person covered in full then subject to coinsurance.	Non-Network Not covered	Network Preventive Care Allowance = 1st \$300/person covered in full then subject to coinsurance.	Non-Network Not covered
<b>Well-Woman Care</b> (office visit, PAP smear test, and STD testing as determined to be appropriate by the provider.)	Must be provided by network providers. No referral required. Subject to office visit copayment. Copayments do not apply towards coinsurance maximum. Related diagnostic tests covered in full.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
<b>Mammogram</b> (recommended frequency age 35-39 = 1 baseline; age 40-49 = every 2 years; age 50+ = annually)	Must be provided by network providers. No referral required. Covered in full.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
<b>Well-Man Care</b> (office visit, PSA blood test and STD testing)	Must be provided by network providers. No referral required. Subject to office visit copayment. Copayments do not apply towards coinsurance maximum. Related diagnostics covered in full.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
<b>Periodic Adult Physical Exam</b>	Must be provided by PCP. Subject to \$20 PCP office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
<b>Dietitian Consultation</b>	As approved by Primary Care Physician. Subject to \$30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
<b>Routine Hearing Exam</b> (Hearing aids NOT covered)	As approved by Primary Care Physician. Subject to \$30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
<b>Routine Vision Exam</b> (Refraction Exam for Glasses - Lenses and frames NOT covered)	Limited to one per year. Subject to \$30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
<b>Age Appropriate Bone Density Screening</b>	As approved by Primary Care Physician. Covered in full.	Network Applies towards Preventive Care Allowance then subject to coinsurance. Must be pre-approved by Health Plan.	Non-Network Not covered	Network Applies towards Preventive Care Allowance then subject to coinsurance. Must be pre-approved by Health Plan.	Non-Network Not covered

### NON-COVERED SERVICES

<b>TMJ/Orthognathic Surgery</b>	Not Covered under Medical - see Dental	Not Covered under Medical - see Dental	Not Covered under Medical - see Dental
<b>Custom Shoe Inserts</b>	Not Covered - see KanElect	Not Covered - see KanElect	Not Covered - see KanElect
<b>Gastric Surgery and Other Weight Loss Treatments</b>	Not Covered - see KanElect	Not Covered - see KanElect	Not Covered - see KanElect

**Coventry Health Care** is a fully insured Health Maintenance Organization (HMO). To enroll in coverage with Coventry Health Care, the participant and all covered dependents must maintain primary residence within the Kansas City/Topeka/Southeast service area or the Wichita/South Central Kansas service area. Coventry has added 9 counties in Kansas and 16 in Missouri. Check the map on page 9 for the service area.

Mental Health/Substance Abuse benefits are coordinated by United Behavioral Health (UBH). If you are seeking care, call UBH (see number below). A separate referral from your PCP is not needed.

**Mailing Address**

Kansas City/Topeka Area:  
 Coventry Health Care of Kansas  
 8320 Ward Parkway  
 Kansas City, MO 64114

Wichita/South Central Area:  
 Coventry Health Care of Kansas  
 8301 East 21st Street North, Suite 300  
 Wichita, KS 67206

**Customer Service Telephone Numbers**

Kansas City/Topeka Area  
 800-969-3343

Wichita/South Central Area  
 866-320-0697

United Behavioral Health (UBA)  
 866-607-5970

FirstHelp  
 800-622-9528 (for health care inquiries)

**Website Address for Provider Directory and Benefit Description**

<http://da.state.ks.us/ps/subject/benlink.htm>



**NOTE:** Provider networks change. Check the website frequently.

**Provider Worksheet**

Providers I use:	Provider in network		Provider qualifies as PCP	
	Yes	No	Yes	No
_____				
_____				
_____				
_____				

**Preferred Plus of Kansas, Inc. (PPK)** is a fully insured Health Maintenance Organization (HMO). To enroll in coverage with PPK, the participants must maintain primary residence within the PPK enrollment area of south central Kansas.

**Mailing Address**

Preferred Plus of Kansas  
8535 E. 21st Street North  
Wichita, KS 67206

**Customer Service Telephone Numbers:**

Toll free: 866-618-1691  
In Wichita: 316-609-2555  
Behavioral Health Services  
316-609-2541 in Wichita  
866-338-4281 in all other areas

**Website Address for Provider Directory and Benefit Description**

<http://da.state.ks.us/ps/subject/benlink.htm>



**NOTE:** Provider networks change. Check the website frequently.

## Provider Worksheet

Providers I use:	Provider in network		Provider qualifies as PCP	
	Yes	No	Yes	No
_____				
_____				
_____				
_____				

**Premier Blue** is a fully insured Health Maintenance Organization (HMO). To enroll in coverage with Premier Blue, the participants must maintain primary residence within the Premier Blue enrollment area.

Mental Health/Substance Abuse benefits are coordinated by Health Management Strategies (HMS). The participant seeking care should call HMS for authorization before services are received (see numbers below). A separate referral from the participant's PCP is not needed.

#### Mailing Address

Premier Blue  
1133 SW Topeka Blvd.  
Topeka, KS 66629

#### Health Management Strategies

Toll free: 800-952-5906  
In Topeka: 785-233-1165

#### Customer Service Telephone Numbers:

Toll free: 800-332-0028  
In Topeka: 785-291-4010

#### Website Address for Provider Directory and Benefit Description

<http://da.state.ks.us/ps/subject/benlink.htm>

**PremierBlue**

**NOTE:** Provider networks change. Check the website frequently.

## Provider Worksheet

Providers I use:	Provider in network		Provider qualifies as PCP	
	Yes	No	Yes	No
_____				
_____				
_____				
_____				

**Kansas Choice** is a self insured PPO plan administered by Blue Cross Blue Shield of Kansas (BCBSKS). BCBSKS is responsible for claims processing and customer service, network management and utilization review.

You do not need to designate a Primary Care Physician (PCP). A nationwide network is available. For the Kansas City Metropolitan area, including Johnson and Wyandotte counties, network providers in most of Kansas are in the Blue Choice Network. In Kansas City, network providers are those which contract as Preferred Care Blue Providers with BCBS of Kansas City. In all other locations, network providers are those which contract with the Blue Card PPO network. Links to the BCBS website and the provider directory are available at <http://da.state.ks.us/ps/subject/benlink.htm>. The initial link is to the BCBSKS directory, with further links to the Kansas City plan and the national Blue Card network.

You may seek care outside of the network benefits by using non-network providers, but you will pay a greater share of the cost when using non-network providers and facilities.

The LabOne lab card benefit is part of the program.

### **Mailing Address**

Kansas Choice  
Blue Cross Blue Shield of Kansas  
1133 SW Topeka Blvd  
Topeka, KS 66629-0001



### **Customer Service Telephone Number**

Toll free: 800-332-0307  
In Topeka: 785-291-4185

### **Website Address for Provider Directory and Benefit Description**

<http://da.state.ks.us/ps/subject/benlink.htm>

**NOTE:** Provider networks change. Check the website frequently.

## **Provider Worksheet**

<b>Providers I use:</b>	<b>Provider in network</b>	
	<b>Yes</b>	<b>No</b>
_____		
_____		
_____		
_____		

**Kansas Prefer** is a self insured PPO plan. Claims processing and customer service are administered by Harrington Benefit Services. Provider network and utilization review are administered by Private HealthCare Systems.

You do not need to designate a Primary Care Physician (PCP). The Private HealthCare Systems network includes over 425,000 professional providers and 3,700 facilities nationwide. In Kansas, including the Kansas City metropolitan area, there are over 137 facilities and in excess of 5,500 providers. You may also seek care outside of the network by using non-network providers, but you will pay a greater share of the cost when using non-network providers and facilities.

The LabOne lab card benefit is part of the program.

**Mailing Address**

Kansas Prefer  
P.O. Box 750  
Pueblo, CO 81002-0750

**Website Address for Provider Directory and Benefit Description**

<http://da.state.ks.us/ps/subject/benlink.htm>

**Customer Services Telephone Number**

Toll free: 800-882-3639

Harrington



**NOTE:** Provider networks change. Check the website frequently.

**Provider Worksheet**

Providers I use:	Provider in network	
	Yes	No
_____		
_____		
_____		
_____		

**Preferred Health Systems** is a fully insured Preferred Provider Organization (PPO). You do not need to designate a Primary Care Physician (PCP). The Preferred Health Systems network includes nearly 4,000 providers in the state. The provider network is primarily a Kansas based network. You may seek care outside of the network benefits by using non-network providers, but you will pay a greater share of the cost when using non-network providers and facilities.

**Mailing Address**

Preferred Health Systems  
Insurance Company  
535 East 21st Street North  
Wichita, KS 67206

**Website Address for Provider Directory  
and Benefit Description**

<http://da.state.ks.us/ps/subject/benlink.htm>

**Customer Service Telephone Numbers**

Toll free: 866-618-1691  
In Wichita: 316-609-2555



**NOTE:** Provider networks change. Check the website frequently.

**Provider Worksheet**

<b>Providers I use:</b>	<b>Provider in network</b>	
_____	<b>Yes</b>	<b>No</b>
_____	<b>Yes</b>	<b>No</b>
_____	<b>Yes</b>	<b>No</b>
_____	<b>Yes</b>	<b>No</b>

## Health Plan Rate Comparison Chart

### For HMO Counties

Rates listed are for medical and prescription drug coverage per semi-monthly (ie 24) deduction period.

Employer Contribution		Preferred Plus of KS HMO	Premier Blue HMO	Coventry HealthCare HMO	Kansas Prefer PPO	Kansas Choice PPO	Preferred Health PPO
Full-Time earning <\$25,000	Employee Only	\$4.49	\$6.56	\$7.46	\$22.50	\$32.27	\$36.20
	Employee + Spouse	\$116.57	\$120.73	\$122.51	\$152.59	\$172.13	\$179.99
	Employee + Child(ren)	\$94.15	\$97.90	\$99.50	\$126.57	\$144.16	\$151.23
	Employee + Family	\$206.24	\$212.06	\$214.55	\$256.67	\$284.02	\$295.03
Full-Time earning \$25,000-\$44,500	Employee Only	\$10.35	\$12.43	\$13.32	\$28.36	\$38.13	\$42.06
	Employee + Spouse	\$122.44	\$126.60	\$128.38	\$158.46	\$178.00	\$185.86
	Employee + Child(ren)	\$100.02	\$103.76	\$105.36	\$132.44	\$150.02	\$157.10
	Employee + Family	\$212.10	\$217.93	\$220.42	\$262.53	\$289.89	\$300.89
Full-Time earning >\$44,500	Employee Only	\$16.04	\$18.12	\$19.01	\$34.05	\$43.82	\$47.75
	Employee + Spouse	\$128.13	\$132.29	\$134.07	\$164.15	\$183.69	\$191.55
	Employee + Child(ren)	\$105.71	\$109.45	\$111.05	\$138.13	\$155.71	\$162.79
	Employee + Family	\$217.79	\$223.62	\$226.11	\$268.22	\$295.58	\$306.58
All Part-Time	Employee Only	\$46.47	\$48.55	\$49.44	\$64.48	\$74.25	\$78.18
	Employee + Spouse	\$173.65	\$177.81	\$179.59	\$209.67	\$229.21	\$237.07
	Employee + Child(ren)	\$148.21	\$151.95	\$153.55	\$180.63	\$198.21	\$205.29
	Employee + Family	\$275.39	\$281.21	\$283.70	\$325.82	\$353.17	\$364.18

**NOTE:** Employer contribution remains the same for a given coverage level regardless of the health plan selected.

## Health Plan Rate Comparison Chart

### For Non-HMO Counties

Rates listed are for medical and prescription drug coverage per semi-monthly (ie 24) deduction period.

	Employer Contribution		Kansas Prefer PPO	Kansas Choice PPO	Preferred Health PPO
Full-Time earning <\$25,000	\$185.50	Employee Only	\$4.96	\$14.73	\$18.66
	\$252.16	Employee + Spouse	\$128.75	\$148.29	\$156.15
	\$238.83	Employee + Child(ren)	\$103.99	\$121.57	\$128.65
	\$305.48	Employee + Family	\$227.78	\$255.14	\$266.14
Full-Time earning \$25,000-\$44,500	\$179.02	Employee Only	\$11.43	\$21.20	\$25.13
	\$245.68	Employee + Spouse	\$135.22	\$154.76	\$162.62
	\$232.35	Employee + Child(ren)	\$110.46	\$128.05	\$135.12
	\$299.01	Employee + Family	\$234.26	\$261.61	\$272.62
Full-Time earning >\$44,500	\$172.75	Employee Only	\$17.72	\$27.49	\$31.42
	\$239.41	Employee + Spouse	\$141.51	\$161.05	\$168.91
	\$226.08	Employee + Child(ren)	\$116.75	\$134.33	\$141.41
	\$292.73	Employee + Family	\$240.54	\$267.90	\$278.90
All Part-Time	\$139.13	Employee Only	\$51.33	\$61.10	\$65.03
	\$189.12	Employee + Spouse	\$191.79	\$211.33	\$219.19
	\$179.12	Employee + Child(ren)	\$163.69	\$181.28	\$188.35
	\$229.11	Employee + Family	\$304.15	\$331.51	\$342.51

**NOTE:** Employer contribution remains the same for a given coverage level regardless of the health plan selected.

# LabOne Program

The LabOne lab card program is a value added feature of the Kansas Choice and Kansas Prefer PPO plans. When a member enrolled in one of these PPO plans uses LabOne for outpatient lab work covered by the medical plan, the cost will be covered at 100% with no copay, no deductible and no coinsurance. Using the lab card program is easy as 1-2-3....

## Telephone:

1-800-646-7788

## Website for Collection Sites

<http://www.labcard.com>

**TIP**

**BE** sure to tell your doctor you want to use **LabOne**.

**1**

When your doctor orders laboratory work for you, show your Lab Card and tell them that you would like to use LabOne. Instructions for your doctor's office are printed on the back of the Lab Card.

**2**

Your doctor's office collects your specimens and calls LabOne for courier pick-up OR your doctor will write out the orders for the lab work and send you to a LabOne collection site.

**3**

LabOne performs the tests and sends the results back to your doctor (usually within 24 hours).



**IT IS YOUR RESPONSIBILITY** to inform the doctor about your lab card eligibility. Present your lab card at the time of service. The ID number on the lab card tells LabOne how to bill your insurance so payment can be made correctly. The collection sites will need a copy of your lab card each time you go for services.

The lab card covers routine outpatient testing. The lab card does **NOT** cover:

- Testing ordered during hospitalization
- Lab work needed on an emergency or (STAT) basis
- Testing done at a lab other than LabOne
- Time sensitive esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests

LabOne has added additional couriers in the State of Kansas and generally a physician can arrange for specimen pick-up two times each day.

LabOne has also added additional collection sites throughout the State of Kansas. A complete list is available on their website: [www.labcard.com](http://www.labcard.com)

Remember – the lab card program is completely voluntary. If you and your doctor elect to use a lab other than LabOne – including the lab in your doctor's office, you still have coverage and regular plan benefits will apply.

## Prescription Drug Plan

**CaremarkPCS**, formerly AdvancePCS, is the Pharmacy Benefit Manager (PBM) administering the self-insured prescription benefit plan offered to participants of the State of Kansas Health Plan. CaremarkPCS has a network of over 65,000 pharmacies nationwide available to plan participants.

Mailing Address (for paper claims)  
CaremarkPCS, Inc.  
P.O. Box 853901  
Richardson, TX 75085-3901

Customer Service Telephone Numbers  
Toll free: 800-294-6324  
TDD: 800-863-5488

### Website Address for Provider Directory and Benefit Description

<http://da.state.ks.us/ps/subject/benlink.htm>

Prescription benefits are included with all medical plans and the cost of this program is incorporated into the medical plan rates.

The Kansas State Employees Prescription Benefit Plan is a five tier program designed to encourage plan participants to partner with their physicians in choosing cost effective medications when needed for the treatment of illness or injury.

The full benefit description, preferred drug list (formulary) and other information related to the Prescription Benefit Plan are posted at: <http://da.state.ks.us/ps/subject/benlink.htm>

**Beginning in 2005, the preferred drug list (formulary) will be updated throughout the year. This means drugs will be added and deleted throughout the year. Be sure to check the preferred drug list often for changes.**



Plan Coverage	Type of Prescription Medication	Participant Pays
Tier 1	Generic Drugs	20% coinsurance
Tier 2	Preferred Brand Name Drugs	35% coinsurance
Tier 3	Special Case Medications (1)	\$75 copay per fill
Tier 4	Non Preferred Brand Name Drugs	60% coinsurance
Tier 5	Lifestyle Medications (2)	100% of discounted price
Coinsurance Max	Tiers 1, 2, & 3 purchases only	\$2,580 per participant/year

(1) Very high-cost medications used to treat generally life-threatening conditions.

(2) Medications used primarily to enhance lifestyle rather than treat an illness or condition.

The coinsurance maximum of \$2,580 per participant per year applies to your coinsurance for Tier 1 – Generic, Tier 2 - Preferred Brand Name and the copay for Tier 3 - Special case medications. Once the coinsurance maximum is reached, claims are paid at 100 percent for Tier1, 2, & 3 drugs for the remainder of that calendar year.

The initial fill of any prescription is limited to a 30-day supply or one standard unit of therapy, whichever is less. Prescriptions can be refilled when 75% of the previous fill has been used. Medications may be refilled for up to a 60-day supply, or two standard units of therapy, if the prescription was written to indicate the larger fill and it is within 90 days of the previous fill for the same medication.

### Mail Order Options

For your convenience, CaremarkPCS offers a mail order option to obtain refills on your prescription medications. This is an especially useful benefit for those drugs you take on a regular basis. In many instances, you will pay less for medications obtained using the Caremark mail order service due to greater discounts and lower dispensing fees. Mail service profile forms are available at:

<http://state.ks.us/ps/benefits.htm>

New prescriptions can be filled by mail. Caremark offers a **"FastStart"** program that allows your physician to fax your new prescription to Caremark. In the **FastStart** program, your order can usually be shipped within 24 hours.

## Specialty RX

An additional feature of the benefit plan is the SpecialtyRx program. This program focuses on patients who utilize medications identified as being given by injection, are used by small patient populations and are costly. The program offers members a convenient source for these high cost injectibles and improved therapy compliance.

Patients who elect to participate in the CaremarkPCS Specialty Rx program will have access to pharmacists or nurses 24 hours per day, 7 days a week. These clinicians specialize in the management of chronic conditions. Of course, you may opt-out of the program if you desire.

## Questions to Ask about Prescribed or Recommended Medications

Every day millions of Americans rely on medications to feel better and get well, but it's not always easy to take them correctly. Taking medicine with certain foods, alcohol, dietary/herbal supplements, or other medications might cause a dangerous reaction, or it might stop your medicine from working as well as it should. Here are some questions that can help you get the information you need to use your medicines properly. If the answers seem complicated or confusing, ask again! (Courtesy of the National Council on Patient Information and Education)

1. What is the name of the medicine and what is it supposed to do? Is this the brand name or the generic?
2. How and when do I take it – and for how long? What if I forget to take it?
3. What foods, drinks, other medicines, dietary supplements, or activities should I avoid while taking this medicine?
4. When should I expect the medicine to begin to work, and how will I know if it is working? Are there any tests required with this medicine (for example, to check liver or kidney function)?
5. Are there any side effects, what are they and what do I do if they occur?
6. Will this medicine work safely with other prescription and non-prescription medicines I am taking?
7. Can I get a refill? If so, when?
8. How should I store this medicine?
9. Is there any written information available about the medicine? Is it available in large print or a language other than English?

Your pharmacist will be able to answer these medication questions as well as any others you may have. Choose your pharmacist as carefully as you choose your doctor because he or she is an important part of your health care team. **It is not uncommon to see more than one doctor, and for this reason, it is very important to use just one pharmacy so your medication records will be located in one place.** Your pharmacist can help you keep track of what you are taking – prescription and non-prescription – and make sure that your medications will not interact harmfully with each other.

## Dental Program

The dental program is a self funded plan administered by Delta Dental Plan of Kansas which is responsible for claims processing and customer service, network management and utilization review. All employees enrolled in medical coverage are also enrolled in the dental program. Employees may elect to purchase dental coverage for their dependents who are enrolled in the State Health Plan.

Sometimes more than one procedure is available which would restore the tooth to function, according to accepted standards of dental practice. If a more expensive service or benefit is selected over a less costly method, the plan will pay based upon the fee for the least costly method needed to restore function. The remainder of the fee will be the responsibility of the participant.

**Participants are encouraged to ask their dentist to send in a pre-determination on high cost and major restorative services being considered before work begins.**

Delta will review the course of treatment and advise you and your dentist of the benefits available for the proposed treatment. Benefits paid for treatment of an accident do not apply toward the annual benefit maximum for other covered services.

### DeltaPremier

The DeltaPremier Network is the broad network of providers that participants may utilize. Delta Dental will make payment directly to the dental provider. The participant will only be responsible for paying the specific coinsurance and deductibles for covered services or for any services not covered.

## DeltaPreferred

In addition to the DeltaPremier network, Delta Dental also offers the DeltaPreferred DPO network. The DPO network providers have agreed to a reduced fee for providing dental services. The DPO network for our group has been expanded to include all DPO providers in the national DeltaUSA DPO network. All participants of the Delta Dental program may use the DPO providers whenever desired.

## Non-Network

Participants may use a dental provider who does not contract with Delta Dental. Non-participating providers may require payment at the time of service. The participant will then need to file their own claims and the plan payment will be mailed to the participant. Payment will be subject to applicable deductible and coinsurance and paid based upon the lesser of the actual charge or the customary fee for the service as determined by Delta Dental. Patients are responsible for the entire balance of charges not paid by Delta Dental.

### Mailing Address

Delta Dental Plan of Kansas  
P.O. Box 49198  
Wichita, KS 67201-9198

### Customer Service Telephone Numbers

Toll Free 800-234-3375  
In Wichita 316-264-4511

### Website Address for Provider Directory and Benefit Description

<http://da.state.ks.us/ps/subject/benlink.htm>



The coinsurance percentage listed is the amount paid by the Delta Dental Plan. Benefits are subject to the terms of the benefit description.

<b>DIAGNOSTIC AND PREVENTIVE SERVICES:</b> Oral examinations, prophylaxis/cleanings (including periodontal maintenance) twice per plan year  Diagnostic x-rays: bitewings twice per plan year for dependents under age 18 and once per plan year for adults age 18 and over.  Full mouth x-rays once each five years.  Topical fluoride twice per plan year for dependent children under age 19.  Space maintainers only for the premature loss of primary molars and only for dependent children under the age of 9.  Sealants are covered for dependent children under age 17 and only when applied to permanent molars with no caries (decay) or restorations on the occlusal surface. Sealants are limited to one per four years.	DPO	Premier	Out of Network*
	100%	100%	100%
<b>ANCILLARY:</b> Provides for visits to the dentist for the emergency relief of pain.	100%	100%	100%
<b>REGULAR RESTORATIVE DENTISTRY:</b> Provides amalgam (silver) restorations on posterior (back) teeth; composite (white) resin restorations on anterior (front) teeth; and stainless steel crowns for dependents under age 12.	80%	60%	60%
The following procedures are subject to a \$45 deductible per person per calendar year not to exceed an annual family deductible of \$135:			
<b>ORAL SURGERY:</b> Provides for extractions and related oral surgical procedures performed by the dentist including pre- and post-operative care.	80%	60%	60%
<b>ENDODONTICS:</b> Includes procedures for root canal treatments and root canal fillings.	80%	60%	60%
<b>PERIODONTICS:</b> Includes procedures for the treatment of diseases of the gums and bone supporting the teeth.	80%	60%	60%
<b>SPECIAL RESTORATIVE DENTISTRY:</b> When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for gold restorations and individual crowns.	50%	50%	50%
<b>PROSTHODONTICS:</b> Bridges, partial and complete dentures, including repairs and adjustments.	50%	50%	50%
<b>TMJ:</b> Treatment is limited to specific non-surgical procedures involving Temporomandibular Joint Dysfunction. A treatment plan must be pre-authorized by Delta Dental.	50%	50%	50%

**ANNUAL MAXIMUM:** The maximum paid by the plan for the above treatments is \$1,600 per person per calendar year.

\* Out of Network Services are subject to the Allowed Amount including the Maximum Plan Allowance for Non-Network Providers. For dental benefits and services provided by a Non-Network Dentist, the Plan will determine the amount payable subject to the Allowed amount and applicable Deductible and Coinsurance. Any amounts in excess of the Allowed Amount will be the patient's responsibility.

## Orthodontic Coverage

Procedures for orthodontic appliances and treatment, including both interceptive and corrective, are covered at 50% only when provided by a Delta Dental Plan participating dentist. Orthodontic treatments are not subject to a deductible and have a \$1,000 per person lifetime maximum. The maximum for orthodontic services does not apply to the regular annual maximum for other covered services. To be covered,

orthodontic treatment must start after the effective date of dental coverage.

## Dental Accidents

Claims for treatment of dental accidents must first be processed by the dental plan. Services not covered by the dental plan can then be considered by the participant's health plan for additional coverage. Payment for treatment for an accident does not apply to the annual maximum for other services.

## Employees cost of coverage

Rates listed below are for Delta Dental coverage only per semi-monthly (i.e. 24) deduction period.

Coverage Level	Full Time Employee	Part Time Employee
Employee	\$0.00	\$2.99
Emp/Spouse	\$7.78	\$11.82
Emp/Children	\$6.22	\$10.05
Emp/Family	\$14.00	\$18.87

**TIP**

**Regular**

check-ups mean fewer cavities.

Use preventive services regularly.

## Vision Program

Superior Vision Services Basic and Enhanced plans are fully insured voluntary vision programs. Employees may elect to enroll themselves and any eligible dependents in one of the vision programs, whether or not the employee or dependents are enrolled in State's medical coverage. However, if dependent vision coverage is selected and dependent children are also enrolled in the medical plan, the dependent children enrolled in vision must match those enrolled in the medical plan. Enrollment, even on an after-tax basis, cannot be changed during the Plan Year unless due to either a newly eligible dependent or to a dependent becoming ineligible.

### Network Providers – How Superior Vision Service Works

To obtain vision care services under the Basic or Enhanced Plans, the participant should contact a Superior Vision network provider. At the appointment, show the ID card or simply indicate enrollment in Superior Vision and provide them the ID number. Superior Vision will pay the network provider for covered services and materials. The patient is responsible for any copayments and any additional costs resulting from cosmetic options, or non-covered services and materials selected.

If the participant has medical coverage through the State, the medical plan will cover one routine eye exam each year. To coordinate benefits with the medical plan, the Superior Vision provider will also need the name of the medical plan and the participant's plan identification number. To maximize benefits, participants need to make sure that their chosen provider is a network provider for both the vision and medical plans.

### Non-Network Providers – How Superior Vision Works

Before a participant receives services from a non-network provider, they should contact

Superior Vision Member Services Department at 1-800-507-3800 to receive an authorization number. After receiving services, the participant is responsible for paying the provider in full and submitting itemized receipts along with the authorization to Superior Vision. Reimbursement will be made according to the reimbursement schedule for non-network providers listed in the benefit description. It is important to note that the reimbursement schedule does not guarantee full payment.

## Superior Vision's Additional Value

### Discounts on additional eyewear

Discounts are available for additional eyewear purchases. The discounts range from 10% to 30% and are available at providers identified in the provider directory with a "DP".

### Discounts on refractive surgeries such as LASIK, RK and PRK

Providers listed in the provider directory with the "RF" designation will provide Superior Vision participants with a discount of 20% on refractive surgeries.

### Website Address for Provider Directory and Benefit Description

<http://da.state.ks.us/ps/subject/benlink.htm>

### Mailing address

Superior Vision Services, Inc.  
P.O. Box 967  
Rancho Cordova, CA 95741

### Customer Service Telephone Number

Toll free 800-507-3800



Superior Vision Services, Inc.

		BASIC PLAN	ENHANCED PLAN	BOTH PLANS
Benefit Type	Benefit Frequency	Network Provider	Network Provider	Non-Network Provider
<b>Subject to \$50 copay</b>				
Eye Exam, M.D.	12 months	Covered in Full	Covered in Full	Up to \$38
Eye Exam, O.D.	12 months	Covered in Full	Covered in Full	Up to \$38
<b>Subject to \$25 materials copay</b>				
Frame	12 months	Up to \$100 Retail*	Up to \$100 Retail*	Up to \$45
Single Vision, Pair	12 months	Covered in Full	Covered in Full	Up to \$31
Bifocal, Pair	12 months	Covered in Full	Covered in Full	Up to \$51
Trifocal, Pair	12 months	Covered in Full	Covered in Full	Up to \$64
Lenticular, Pair	12 months	Covered in Full	Covered in Full	Up to \$80
Progressive lens, Pair	12 months	Not Covered	Covered up to \$165*	Not Covered
High Index lenses	12 months	Not Covered	Covered up to \$116**	Not Covered
Poly-carbonate lenses	12 months	Not Covered	Covered up to \$116**	Not Covered
Scratch Coat	12 months	Not Covered	Covered in Full	Not Covered
UV Coat	12 months	Not Covered	Covered in Full	Not Covered
<b>Not subject to materials copay</b>				
Contact Lenses, Medically Necessary	12 months	Covered in Full	Covered in Full	Up to \$210 retail
Contact Lenses, Elective-Cosmetic	12 months	Up to \$150 retail*	Up to \$150 retail*	Up to \$105 retail

\* Participants are responsible for any charges above the allowance.

\*\* Participants may use only one of the lens allowances per purchase. Participants are responsible for any charges above the allowance.

- Participants can use either the contact lens benefit or the eyeglass benefit, but not both in the same Plan Year.
- Non-Network Claims - copay amount(s) is deducted from the benefit allowance at the time of reimbursement.
- Covered lenses are standard glass or plastic (CR-39), clear.

Rates for vision coverage per semi-monthly deduction period.

Coverage Level	Basic Plan	Enhanced Plan
Employee only	\$2.13	\$3.49
Emp/Spouse	\$4.26	\$6.98
Emp/Children	\$3.84	\$6.28
Emp/Family	\$5.97	\$9.77

**KANELECT** is an Internal Revenue Code, Section 125 plan offered by the State of Kansas. This program allows for the dollars you spend on certain expenses incurred throughout the year to be exempt from taxes. The KanElect program is comprised of three separate benefits.

### KanElect Options

- Pretax Premium Option – allows the employee to pay for the cost of employee sponsored health plan premiums on a pretax basis.
- Health Care Flexible Spending Account (FSA) – allows the employee to use pretax earnings to pay for certain incurred medical expenses allowed by the IRS but not reimbursed by medical, dental, prescription drug or vision insurance. Insurance premiums and other premiums are not reimbursable expenses in an FSA.
- Dependent Care Flexible Spending Account

(FSA) – allows the employee to use pretax earnings to pay for work-related child care or adult care expenses.

### Enrollment

Employees who want to participate in either the Health Care or Dependent Care FSA in 2005 must enroll during Open Enrollment. Enrollment in an FSA does not roll forward from year to year. Open Enrollment elections for 2005 will become effective on January 1, 2005.

### How Much Should I Deposit

It's important that you calculate the right amount to contribute to your FSA account. The IRS regulations state that if you don't use all of the money in the account when the year is over, those funds will no longer be available to you. A worksheet is located on the next page to help you figure out the right amount to put into your account. The minimum and maximum amounts eligible for deposit per semi-monthly deduction period are as follows:

Health Care FSA			Dependent Care FSA	
Minimum	Maximum	Payroll Periods	Minimum	Maximum
\$8.00	\$132.00	- 24 deduction period employee	\$16.00	\$208.33*
\$12.00	\$198.00	- 16 deduction period employee (regents)	\$24.00	\$312.50*

\*Subject to tax filing status

**Expenses eligible for reimbursement are those incurred from January 1, 2005 through December 31, 2005. Claims must be filed by March 31, 2006.**

Additional information can be viewed in the Employee Benefits Guidebook which is located at the following website: <http://da.state.ks.us/ps/benefits.htm>

### Mailing address

ASI  
P.O. Box 6044  
Columbia, MO 65205-6044

### Customer Service Telephone Number

Automated Infoline (24 hours) 800-366-4827  
(Customer Service representatives available  
7am to 7pm on workdays)

### Website Address

<http://www.asiflex.com>

# Health Care FSA Worksheet

Use this worksheet to help you determine your **Health Care FSA** election amount. You may want to review receipts from last year for health care expenses you paid out of your own pocket. You cannot increase, decrease or cancel your KanElect contribution during the Plan Year unless you experience a status qualifying event.

## Deductibles

Medical, dental, vision \$ \_\_\_\_\_

## Copayments/Coinsurance

The amount not paid by your plan coverage \$ \_\_\_\_\_

## Amounts paid over allowed

The amount paid over reasonable and customary allowance \$ \_\_\_\_\_

Subtotal A \$ \_\_\_\_\_

## Expenses NOT covered by insurance plan

Vision care \$ \_\_\_\_\_

Dental/orthodontic care \$ \_\_\_\_\_

Prescription drugs \$ \_\_\_\_\_

Over-the-counter drugs \$ \_\_\_\_\_

Fees/Services \$ \_\_\_\_\_

Treatments/therapies \$ \_\_\_\_\_

Medical Equipment \$ \_\_\_\_\_

Assistance for the disabled \$ \_\_\_\_\_

Other eligible expenses\* \$ \_\_\_\_\_

Subtotal B \$ \_\_\_\_\_

## Out-Of-Pocket Health Care Expenses

This gives you a good idea of the amount you should elect to place into your Health Care FSA. Consider any other factors that will affect your out-of-pocket health care costs during the upcoming plan year, and adjust the amount if necessary.

(Add Subtotals A & B) \$ \_\_\_\_\_

\*Eligible expenses include any expenses considered deductible by the IRS for federal income tax purposes. See IRS Publication 502 for more information.

## Dependent Care FSA Worksheet

Use this worksheet to help you determine your **Dependent Care FSA** election amount. The Dependent Care FSA allows you to use pre-tax dollars to pay for child care services that make it possible for you and your spouse (if applicable) to work. Under certain circumstances, it also may be used to help pay for the care of elderly parents or a disabled spouse or dependent.

**Note that the Dependent Care FSA is intended to cover costs of care and does not cover any medical or health care costs for your dependents.**

## Child Care Expenses

Day Care Center \$ \_\_\_\_\_

In-home Care \$ \_\_\_\_\_

Nursery and Preschool \$ \_\_\_\_\_

After School Care \$ \_\_\_\_\_

Au Pair Services \$ \_\_\_\_\_

Summer Day Camps \$ \_\_\_\_\_

## Elder Care Services

Day Care Center \$ \_\_\_\_\_

In-home Care \$ \_\_\_\_\_

## Out-Of-Pocket Dependent Care Expenses

This total gives you an estimated amount that you should elect to place into your Dependent Care FSA.

Total \$ \_\_\_\_\_

Note: The individual dependent care FSA total shall not exceed \$5,000 (\$2,500 in case of separate return by a married individual).

**THE EMPLOYEE BENEFITS GUIDEBOOK** is a complete listing of the policies regarding the benefits plans. The Guidebook is located on the State of Kansas website:

<http://www.accesskansas.org/employee>

### Medical Insurance Plans

Eligibility for all plans is determined by county of residence (based on the city and state of residence). The Open Enrollment screen will display only those plans that are available in the employee's county of residence. For HMOs, the employee and all covered dependents must reside within the designated enrollment area for the State of Kansas group.

### Medical and Prescription Drug Coverage

All employees and dependents with medical coverage will also have prescription drug coverage.

### Dental Coverage

Single dental coverage is provided for all employees enrolled in medical coverage. Employees may choose to add dependent dental if dependent medical coverage is selected; the dependents enrolled in the dental plan must match those enrolled in the medical plan.

### Vision Coverage

Plan Year 2004 vision plan enrollment will roll into Plan Year 2005 unless a change is made online. Employees may elect any level of coverage in either the Basic or Enhanced Superior Vision Plan regardless of enrollment in a medical or dental insurance plan. If you elect to enroll dependent children in medical and vision coverage, the same children must be enrolled in both.

Note: Employees may waive medical, drug, and dental coverage and still enroll in the voluntary vision plan.

### Required Information

The following information is required for each employee and dependent covered by the Health Plan:

- Relationship (e.g., child, spouse, stepchild, etc.) Documentation to support proof of relationship or dependency is required.
- Full Name
- Social Security Number
- Gender
- Date of Birth
- PCP (Primary Care Physician) Number—for initial enrollment only on all HMO options. PCP designations should be made via online enrollment only if selecting a new HMO option. To change PCP at any time without changing carriers, call the HMO.

### Dependents

Eligible dependents include, but are not limited to:

- An employee's lawful wife or husband. When the employee has been divorced from the lawful wife or husband, such spouse no longer qualifies as the employee's lawful wife or husband.
- An employee's unmarried child who:
  1. Is less than 23 years of age;
  2. Does not file a joint tax return with another taxpayer;
  3. Receives more than half of their support from the employee; and
  4. Is a U.S. citizen, a U.S. national or a resident of the U.S., Canada or Mexico at some time during the tax year.

For a more complete listing of those qualifying as a dependent, see the Employee Benefits Guidebook.

## Qualifying Events

Open Enrollment is your annual opportunity to make changes to your health care coverage. You may not make changes to your health or dental elections until next year's Open Enrollment period unless you experience a qualifying event. If you experience a qualifying event, you have an opportunity to make changes to your coverage level and/or plan before the next Open Enrollment period.

**IMPORTANT**

**You must contact your agency's Human Resource office and complete an enrollment or change form for all changes within 31 days of the qualifying event.**

Qualifying events include, but are not limited to:

- Birth or adoption of a child
- Marriage
- Divorce
- Spouse's gain or loss of employment
- Death of spouse or dependent

For a complete list of qualifying events, see the Employee Benefits Guidebook.

# Open Enrollment...

## Have You

- ✓ Read all of the Open Enrollment materials?
- ✓ Attended an Open Enrollment meeting held in your area?
- ✓ Determined whether or not you want to make any changes to your current health plan?
- ✓ Called your health care provider's office to ask whether your doctor (or a doctor you wish to see) participates in the plan you have chosen and, if applicable, is accepting new patients?
- ✓ Submitted documentation to your personnel officer such as birth certificates or marriage license for dependents you are adding for the first time?
- ✓ Enrolled or re-enrolled for health care or dependent care FSA?
- ✓ Saved & submitted the online Open Enrollment form?
- ✓ Printed a summary of elections after selecting "SUBMIT/SAVE" in the online Open Enrollment system?

## When Talking to Your Doctor...

- Make a list before you go to your appointment. Start with the most important items.
- Be honest. It is in your best interest. Your doctor can give you the best treatment only if you are open about what is really going on.
- Stick to the point. Each patient is given a limited amount of time, so make the best use of your time. Give the doctor a brief description of the symptom, when it started, how often it happens, and if it is getting better or worse.
- Share your health history. Tell your doctor your health history and how your health is now. Review with your doctor a prevention plan. Don't forget to discuss health issues that your parents and relatives have as this may provide insight into your health.
- Share your point of view. Your doctor needs to know what is, or is not, working. Voice your feelings in a positive way.
- Ask questions. If you don't ask questions, your doctor may think that you understand why you are being sent for a test or that you don't want more information.
- Always ask for your options or alternative treatments.
- Always ask for possible outcomes or what you can expect.

# Improve Your Health...

## and Reduce Your Costs

By the year 2000, Americans were spending \$1.3 trillion annually in health care - more than what was being spent on food, housing, or national defense. That figure is expected to more than double by 2012. These expenses have increased the cost of health insurance in both the public and private sectors. The State of Kansas Employees Health Plan is no different.

The Health Plan has identified ways that you can reduce the cost of your health care while improving your health.

- **Enroll in KanElect.** This Internal Revenue Code, Section 125 plan allows you to set aside money on a pre-tax basis in a health care account which you can use to reimburse yourself for approved medical expenses not covered by your medical, prescription drug, dental or vision plans.
- **Take Advantage of the Mail Order Pharmacy.** The Mail Order Pharmacy through CaremarkPCS is a convenient and cost effective way to obtain your long-term medications through the mail.
- **Use Generic Prescription Drugs When Possible.** Less expensive, FDA-approved generic equivalents are as effective as brand names - at about one-third of the cost.
- **Manage Stress.** Stress directly and indirectly contributes to the leading causes of death in the United States, and aggravates many other conditions. Managing stress - whether you get more exercise, take deep breaths, or cut back on coffee - can make your life easier and your health costs lower.
- **Stay Active.** Regular exercise - even just walking 30 minutes a day, three days a week - can cut the risk of conditions such as high blood pressure, heart disease, and diabetes.
- **Stop Smoking.** The lifetime medical costs for smokers are nearly one-third higher than those of non-smokers. Kicking the habit may save your life - and save you money too.
- **Use the ER for Emergencies Only.** Whenever someone goes to the emergency room for non-emergency care, we all pay the price. Emergency room visits are substantially more expensive than physician office visits. Don't ever hesitate to go to the ER if it's a true emergency. But if it's not, check with your doctor first.
- **Participate in the Disease Management Programs.** Conditions such as asthma, diabetes, depression and coronary artery disease account for more than \$100 billion in health care expenses nationally every year. These programs are available to assist eligible participants in maintaining or enhancing their health through self-care management and effective communications with their physician. The programs are offered by invitation and are free to eligible participants.
- **Lose Weight and Eat Right.** Studies show that obesity adds \$7.7 billion to the nation's annual health care bill, and is associated with 63 million additional doctor visits annually. A balanced diet reduces the potential of a wide range of illnesses including type 2 diabetes, hypertension and heart disease.

**Allowable Charge** - The maximum amount a health plan will pay for a covered service. Network providers and facilities are those who have agreed to accept the allowable charge for covered services under the plan.

**Billed Charges** - The difference between the allowed and actual charge. A network provider will write off this amount (discount). A non-network provider will usually not write off this amount and it will become your responsibility to pay.

**Coinsurance** - Coinsurance is the percentage of covered medical expenses a member must pay in conjunction with the percentage paid by an insurance plan for covered expenses. These amounts are called coinsurance because both the member and the insurance plan share the cost of health care expenses.

**Coinsurance Maximum** - A set dollar amount identified in the contract of insurance. Once the amount you pay out of your pocket as coinsurance reaches this amount, covered services are paid at 100% of the Allowed Charge with no further Coinsurance being applied for the remainder of the Plan Year. You may be responsible for amounts that exceed the Allowed Charge if you are receiving services from a non-network provider.

**Coordination of Benefits** - A system to eliminate duplication of benefits when a person is covered under more than one group health plan. Benefits under the two plans are limited to no more than 100 percent of the claim.

**Copayment** - A copayment is a fixed dollar amount of covered medical expenses a member must pay in addition to what is paid by an insurance plan for covered expenses. These amounts are called copayments because both the member and the insurance plan share the cost of health care expenses.

**Covered Medical Expense** - The Allowable Charge for a medical procedure that is covered by the contract of insurance and is deemed medically necessary by the health plan in the diagnosis or treatment of an illness or injury.

**Deductible** - A set dollar amount you must pay out of your pocket each year from Covered Medical Services before the insurance plan begins to pay claims. The Deductible is shown on the Schedule of Benefits of the policy.

**Exclusion** - A specific condition or circumstance for which an insurance plan or policy will not provide benefits.

**Explanation of Benefits (EOB)** - A statement sent to a participant by the health plan that indicates the name of the provider, total amount billed, amount paid by the plan, and amount the patient is responsible for paying to the provider. This is not a bill and should be retained to show how the claim was processed.

**Fully Insured** - Under a fully insured plan the employer purchases coverage from an insurance company. The insurance company assumes the risk to pay all health claims.

**Health Maintenance Organization (HMO)** - A managed care plan that has contractual arrangements with healthcare providers (doctors, hospitals, etc.) who together form a provider network. HMO members are required to see only providers within this network. If a member receives care outside of this network, the HMO will not pay benefits for these services unless the care was pre-authorized or deemed an emergency. Members choose a primary care physician (PCP) who coordinates all aspects of the member's healthcare. To receive benefits, members must receive a referral from their PCP before they can see a specialist.

**Medically Necessary** - Services or supplies ordered by a physician or provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the patient receives the service and in the least costly setting required for the patient's condition. The service must be consistent with the patient's

illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

**Pre-Admission Certification** - A plan requirement that you call the health plan prior to admission to the hospital. The phone numbers to call are listed in this health plan summary booklet. Pre-certification is not a guarantee that benefits will be paid.

**Preferred Provider Organization (PPO)** - A PPO has arrangements with doctors, hospitals and other providers who have agreed to accept the plan's allowable charge for covered medical services as payment in full and will not balance bill you. Participating providers also file claims for you. You can see anyone in the network of providers.

**Qualifying Event** - An event that allows changes to insurance coverage or an extension of insurance coverage for an employee, spouse or dependent. Such events may be marriage, birth/adoption/placement, loss of group health plan coverage, divorce/legal separation, death of the covered employee, loss of dependent's eligibility for coverage, etc. When a qualifying event occurs you have 31 days to contact your personnel officer and complete the forms in order to make the change to your membership.

**Self Insured** - Self insured plans are set up by employers to pay the health claims of its employees. The employer assumes the risk of providing the benefits and is obligated to pay all the claims.

## Resources for Health Information

There are many valuable tools available to assist you in managing your health.

- Health Plan Summary Booklet – provides information on the health plans available to you, costs of the plans, flexible spending accounts, and tips to get the most out of the plans you choose.
- Your Human Resource or Personnel officer
- Customer service staff for the plan in which you are enrolled
- HealthQuest – newsletters, bulletins, and special programs

Employee Benefits Guidebook – a complete listing of the policies regarding the State of Kansas Employees Health Plan. The Guidebook is located on the State of Kansas website at **<http://da.state.ks.us/ps/benefits.htm>**

**<http://www.ahrq.gov>** - Agency for Healthcare Research and Quality. This site includes a pocket guide to good health for adults. It provides information on health conditions/ diseases/ prescriptions/ prevention & wellness.

**<http://www.stayinginshape.com>** - How to stay healthy. Here you'll find information on diseases/ conditions/ interactive tools/ calculators/ health quizzes, etc. This site is offered in English and Spanish.

**<http://www.collaborativecare.net>** – Includes links to more than 20 good health resources. This site helps patients become informed about their medical options, communicate effectively with their doctors, and achieve better overall health outcomes.

**<http://www.ama-assn.org>** - American Medical Association website. Site includes general legislative information and publications on public health.

**<http://www.nih.gov>** - National Institutes of Health. A source for general background information on health conditions and research. Here you will find "Talking with your doctor – A guide for older people" which is good information for anyone.

**<http://www.cdc.gov>** - Centers for Disease Control. This site includes health and safety topics/ publications and products/ data and statistics.

**<http://www.npsf.org>** - National Patient Safety Foundation. A resource that provides a library of information on patient safety.

**<http://www.ksinsurance.org>** - This site includes useful information on how to "Take Control" of your health care.